NH BOARD OF MEDICINE
2 INDUSTRIAL PARK DRIVE, SUITE 8
CONCORD, NH 0330143520
(603) 271-1203

MEDICAL RECORDS RELEASE AUTHORIZATION

TO WHOM IT MAY CONCERN:

I, the undersigned, _____

do hereby authorize any physician, hospital, institution, other person, firm, or corporation to release (upon presentment of this authorization or any photostatic copy of the same) to any member or agent of the New Hampshire Board of Medicine, by certified mail, or to any designee thereof, or to bearer, any information, records, x-rays, paper, notes, and histories, or any other papers concerning any treatment, examinations, periods of stays of hospitalization, confinement, diagnosis, or other information pertaining to and concerning my physical and/or mental condition. This authorization also includes authority to copy any and all papers, record, etc. This authorization is continuing in nature and is to be given full force and effect to discover information of any of the foregoing learned and determined after the date hereof.

Dated at _____ this _____ day of _____, 19___.

Date of Birth: _____

Signed: _____

Witnessed: _____